

# Intimate Partner Violence in the Adolescent

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## Practice Gaps

Clinicians need to provide universal education and anticipatory guidance regarding healthy relationships, including sexual relationships. Clinicians also need to understand the profound impact of trauma and violence on adolescent health and how to prevent and intervene in abusive relationships.

## Abstract

Intimate partner violence among adolescents (also called adolescent relationship abuse or teen dating violence) is common and is associated with poor health and social outcomes. Pediatric providers are uniquely positioned to offer universal education (anticipatory guidance) about healthy and unhealthy relationships to all their adolescent patients. Pediatric practices can ensure that youth know about available resources and supports for relationship abuse (for themselves or for their friends) and can facilitate safe connections to victim service advocates.

## Objectives

 After completing this article, readers should be able to:

1. Recognize the high prevalence of intimate partner and sexual violence and the impact of such violence on youth and families.
2. Improve skills in eliciting a sexual history that empowers adolescents to recognize healthy and abusive relationships.
3. Become an advocate for health and safety by helping youth learn about and connect to local resources and online support for adolescent relationship abuse.

**AUTHOR DISCLOSURE** Dr Rome has disclosed that she is on the speakers' bureau and vaccine advisory board for Merck. Dr Miller has disclosed no financial relationships relevant to this article. This commentary does not contain a discussion of an unapproved/investigative use of a commercial product/device.

### ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
IPV	intimate partner violence
STI	sexually transmitted infection

### DEFINITIONS AND EPIDEMIOLOGY

The Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) as physical, emotional, or sexual violence that occurs between 2 people in an intimate relationship. (1) The pattern of reproductive coercion can include repeated physical abuse and injury, progressive isolation, intimidation,

demanding sex, and other controlling behaviors. (2) Reproductive coercion, a distinct form of IPV, involves pressuring a partner to become pregnant or sabotaging contraceptive attempts. IPV and reproductive coercion can result in negative health consequences, including unintended pregnancy, sexually transmitted infections (STIs), depression, anxiety, and posttraumatic stress disorder. (3)(4)(5) IPV has been studied more in heterosexual relationships but occurs among same-sex, bisexual, and transgender individuals in relationships as well. (6) IPV among adolescents (often called teen dating violence or adolescent relationship abuse) involves physical, emotional, and/or sexual abuse that happens in a relationship when 1 or both parties is a minor. Adolescents may misread controlling behaviors such as jealousy and possessiveness as evidence of true love, especially if they have not had any role modeling of mutually respectful and healthy relationships.

IPV occurs in 1 of 3 women globally, including in the United States. (7) In a meta-analysis from the World Health Organization's data from 81 countries, the lifetime prevalence of physical and/or sexual IPV in girls ages 15 to 19 years who had ever been in an intimate relationship was 29.4%, and in the 20- to 24-year-old age group was 31.6%, underscoring that this is an adolescent health concern. (8) In the United States, an estimated 1 in 3 women has experienced IPV. (7) In sheer numbers, IPV has been estimated to impact 12 million women and men annually. (9)(10)

Among high school students who have been in a relationship, the past-year prevalence of any physical or sexual IPV is approximately 21% for girls and 10% for boys. (11) In a study in California school-based health centers, 18% of adolescent girls ages 14 to 19 years reported that they had experienced physical or sexual IPV in the past 3 months, with a higher likelihood of reproductive coercion in those experiencing physical or sexual IPV. (12) In a study of college-aged women, nearly half of those surveyed had been victims of IPV. (13)

In 2004, IPV was associated directly with 1,544 deaths in the United States, with 3 of 4 victims being female. (14) This number is thought to be a significant underestimate because deaths may not be reported as being related to IPV. IPV also often precedes child maltreatment, including physical and emotional abuse of the child. Given the overlap of IPV and child maltreatment, parents who disclose experiencing IPV should also be offered support and resources to ensure their own and their children's safety.

## IPV AND EFFECT ON CHILDREN

An estimated 3% to 19% of pregnant women have been victims of IPV, with potential harm to the fetus. (15) In utero

exposure to IPV increases the risk of preterm labor, low birthweight, intracranial hemorrhage, and neonatal death. (2) IPV is also costly; Rivara et al (16) noted that the offspring of women who have been victims of IPV use health-care more frequently, even if the abuse ceased before delivery.

The Adverse Childhood Experiences Study has highlighted the long-term effects of IPV on children. Compared with adults raised in homes without IPV, adults raised in homes where a parent experienced IPV were 4.8 times more likely to have been physically abused, 6 times more likely to have been emotionally abused, and 2.6 times more likely to have been sexually abused. (17) The Table lists potential signs of exposure to IPV as a child, recognizable via internalizing and externalizing behaviors. Some of the known individual- and social-level factors that increase risk of exposure to IPV in adolescents include depression, alcohol and drug use, exposure to violence as a child (including witnessing parental IPV and childhood sexual abuse), previous violence victimization (including bullying and homophobic teasing), having a disability (such as a physical or sensory impairment), experiencing marginalization and discrimination due to such issues as sexual orientation or sex identity, unequal social norms that condone sex-based violence, and laws and policies that perpetuate sex inequality.

Previous exposure to violence victimization (including witnessing parental IPV) is a critical factor and underscores the importance of prevention and intervention strategies for children exposed, including trauma-focused prevention programs and treatment in schools.

Adolescents also may not recognize particular behaviors as being abusive. In a study involving 841 girls ages 16 to 19 years and 1,387 young women ages 20 to 24 years recruited from 24 family planning clinics in western Pennsylvania, Jones et al (18) found that both IPV and reproductive coercion correlated with STIs and poor condom use. Young women experiencing reproductive coercion were also less likely to recognize specific behaviors as abusive (such as being pressured to have sex or a partner threatening to hit her) compared with women who had not experienced reproductive coercion. Condom manipulation, birth control sabotage, and pressure to get pregnant against her wishes are hallmarks of reproductive coercion that many young women may not recognize as controlling and abusive behaviors that undermine their reproductive autonomy. (19) A critical role of pediatric providers is increasing awareness among adolescents and young adults of the range of abusive behaviors in relationships that have a direct effect on their health and wellness.

**TABLE. Potential Signs of Exposure to Adverse Childhood Experiences, Including Intimate Partner Violence**

<b>Internalizing behaviors:</b>
Depression
Suicidal ideation
Anxiety
Withdrawal
Somatic complaints (chronic abdominal pain, headaches, etc)
Poor sleep
School avoidance
Disordered eating: both overeating and food restriction
<b>Externalizing behaviors:</b>
Attention problems
Academic underachievement
Aggressive behavior at school, at home, or in the community
Rule-breaking behaviors
Difficulty forming and maintaining stable relationships with peers
Bullying behaviors
Substance abuse
Sexual health behaviors such as early-onset sexual activity, multiple partners, difficulty negotiating partner condom use

### SOCIAL AND CONTEXTUAL FACTORS THAT CONTRIBUTE TO IPV

From a population health perspective, sex inequality is considered a root cause of violence against women and girls. (20) Issues are not unique to any one ethnicity or subgroup but have been studied in various unique populations. (21)(22) In a longitudinal study of Latino youth in the United States followed from 10th grade until age 22 years, Latino boys who were more acculturated to living in the United States in 10th grade demonstrated a significantly higher risk of subsequently perpetrating physical IPV by age 22 years, whereas greater retention of Hispanic culture predicted less IPV in early adulthood. In contrast, girls' acculturation did not show similar associations. For girls, lifetime alcohol use by 10th grade predicted higher risk of psychologic IPV victimization in emerging adulthood. (23) Consistent with previous studies, the authors found that histories of childhood abuse and witnessing parental domestic violence were the strongest predictors of both

IPV perpetration and victimization in this sample of Latino youth. Similar studies related to sex-equitable attitudes and violence have found that adolescent boys (32.4% white, 23.7% non-Hispanic black, 13.9% Hispanic, 7.7% Asian, and 4.9% Native American/Pacific islander) who endorse traditional sex roles have a greater likelihood of IPV perpetration in adolescence compared with adolescents with more equitable attitudes, regardless of race/ethnicity. (24)

### HOW CAN PEDIATRICIANS SUPPORT ADOLESCENTS AND HELP PREVENT IPV?

#### In the Office

Given the high prevalence of IPV, pediatricians are key adult allies in supporting young people in navigating their relationships, preventing IPV, and supporting those who have already been exposed to such violence. Although there are certainly red flags for an unhealthy relationship, youth may not disclose being in an unhealthy or abusive relationship for myriad reasons, including 1) fear of the perpetrator of IPV; 2) fear of breaches of confidentiality; 3) lack of trust in adults, including health-care professionals and clinicians; 4) desire to protect the abusive partner or the parent; 5) self-blame and inappropriately placed guilt; 6) lack of recognition of what constitutes abusive behaviors; 7) inability to access care (lack of transportation, uncertainty about insurance coverage); and 8) lack of knowledge of services or of scope of services (uncertainty about where to seek care).

Currently, assessment and counseling for IPV is recommended by the American College of Obstetricians and Gynecologists, the American Medical Women's Association, the American Medical Association, and the National Academy of Medicine, a part of the National Academies of Science, Engineering, and Medicine. (25)(26)(27) Depending on an adolescent's developmental stage, relationship abuse and reproductive coercion may also be misinterpreted by the adolescent as true love rather than as overly possessive or abusive behavior. Open-ended questions have a role, and some concrete questions can help educate adolescents about what unhealthy relationships look like. When eliciting a history of sexual abuse, rather than asking "Have you ever been raped?" the clinician might try "Has anyone ever done anything sexually that made you uncomfortable?" Similarly, rather than asking "Are you in an abusive relationship?" the clinician can ask "Does the person you're seeing get mad at you if you do not respond to his/her calls right away?" or "Has someone you were going out with ever monitored your phone or texts in a controlling way?" The goal with such routine inquiry about relationships and asking about coercive behaviors also provides an opportunity for universal

education about healthy and unhealthy relationships regardless of disclosure. All adolescents should leave their clinical encounter with information about IPV and resources available to them and to their friends.

Parents, including teen parents, experiencing IPV are more likely to seek help for their child than for themselves. The pediatrician needs to remember that the signs of IPV can be subtle, overlapping with anxiety, depression, or posttraumatic stress disorder. Other red flags include failure to keep medical appointments, frequent medical visits with somatic complaints that do not fit with the medical history, and reluctance to answer questions about discipline strategies at home. Again, with adults as well, the goal is not to force patients or parents to disclose experiences of violence. Rather, the role of the pediatric provider is to ensure that all parents receive information about IPV and the effect on their and their child's health. This should include information about supports and services in the clinic as well as local and national resources (eg, the National Domestic Violence Hotline [[www.thehotline.org](http://www.thehotline.org)]; educational safety cards for parents are also available from IPV Health Partners [[www.ipvhealth.org](http://www.ipvhealth.org)]).

Through establishing confidentiality and reminding adolescents and their parents of the definition and limits of confidentiality, the clinician can create safe spaces for discussion of sensitive topics while not pushing for disclosure. The clinician can state, for example, "Everything we talk about without a parent in the room is confidential, meaning I am not going to share with your parent what you tell me unless it is life-threatening or dangerous. With all young people I take care of, if I learn that they are in danger, I work hard to partner with them to keep them safe, and sometimes we need outside support to make that happen. My job is to keep all young people safe and healthy, so you can be an active manager of your own health. What questions do you have for me about that?"

Awareness of the laws surrounding consent and confidentiality of adolescents can help keep each adolescent victim of IPV safer. Reporting a case of suspected IPV to a child protective services agency or law enforcement without consultation with social work and other multidisciplinary teammates (including victim service advocates) may result in inadvertently compromising a young person's safety. When filing a child abuse report on behalf of an adolescent, whenever possible, the adolescent should be included in the filing process.

Clinicians should also be mindful of documenting relationship and sexual health concerns confidentially, especially in an era when parents and adult caregivers may have access to an adolescent's electronic health record via a

patient portal. In the routine social history, clinicians can consider using a phrase such as the following: "A detailed psychosocial assessment was conducted and documented confidentially, and appropriate resources and educational materials were reviewed with the patient." Clinicians should work within their health-care systems to ensure that their electronic health record has a way to protect the confidentiality of adolescent records.

### Beyond Screening: Reframing the Role of the Pediatrician in Prevention

Given the prevalence of IPV and the multiple barriers to care seeking, the goal in each clinical encounter is not to push for a disclosure of IPV but rather to inform and support patients about the critical importance of healthy relationships. From a public health perspective, primary, secondary, and tertiary prevention approaches can help reduce IPV in adolescents and young adults. Primary prevention consists of educating and supporting teens and tweens to recognize healthy and unhealthy relationships and be advocates for their and their peers' health and safety. Because middle school is a time when early adolescents and preteens often first explore relationships with peers and may begin dating, interventions in the school, the community, the home, and the office can augment a young person's understanding of what is considered healthy behavior in a relationship. Examples of unhealthy relationship behaviors include monitoring a partner's cell phone use; controlling where and with whom a partner can talk or hang out; telling a partner what he or she can or cannot wear; manipulating contraceptive use, including refusing to use condoms or putting holes in them, throwing away oral contraceptive pill packs, and other strategies; possessive behaviors, including isolating an adolescent from friends/family; inappropriate anger at the victim if calls are not answered or responded to immediately; and pressure to participate in sexting or "textual harassment." (28)

The pediatrician should ask the teen about these warning signs, with phrasing such as "I ask all my patients about the relationships they are in, and about how everyone deserves to be treated with respect and trust. Some of my patients tell me about how a friend or partner constantly checks up on them or puts them down; has anything like that ever happened to you?" If the answer is no, clinicians should still share an educational resource, such as a palm-sized educational brochure, with examples available from websites such as Futures Without Violence ([www.futures-withoutviolence.org/hanging-out-or-hooking-up-2](http://www.futures-withoutviolence.org/hanging-out-or-hooking-up-2)). The clinician can then empower the teen to share this information with friends or family, using phrases such as "I am glad

to hear that's not happening to you. If you know a friend who could use this information, please take along this [brochure/handout/website link] for them. Feel free to take several to share with others who could use them." Primary prevention makes each teen an active "upstander," rather than a passive bystander, for IPV and reproductive coercion.

Adolescents may feel more empowered to help a friend rather than remain a silent observer; this kind of intervention promotes challenging those social norms that condone and normalize IPV and adolescent relationship abuse. Moreover, including educational material on IPV and reproductive coercion during a health-care visit can reduce the stigma around IPV and simultaneously educate young people on what constitutes a healthy relationship; this normalization of prevention messaging would also allow the health-care site, school, or other venues providing services to be identified as safe spaces in which relationship concerns and IPV may be discussed.

Primary prevention in the digital age includes asking about media use and helping adolescents become aware of their digital footprint and create boundaries for themselves, and support those boundaries for friends. One teen-friendly resource is That's Not Cool.com ([www.thatsnotcool.com](http://www.thatsnotcool.com)), a website through which teens (and their parents) can learn about setting such boundaries or drawing their own "digital line."

Secondary prevention means recognizing and addressing a problem in its early stages. A diagnosis of recurrent STIs, adolescent pregnancy, depression, academic underachievement, or other problems should trigger the clinician to consider the possibility of IPV (and overlapping concerns of sexual assault and sexual exploitation) in the differential diagnosis. The pediatrician can ask questions that promote safe disclosure, such as "When I see a pattern of STIs (or infections) or when I detect a teen pregnancy, I worry about people making you do things sexual when you didn't want to. Could that be part of your story?" and then, open-endedly, "Tell me more." As with parents who are victims of IPV, similar red flags for adolescents include repeated visits for somatic complaints (eg, headaches, chronic stomachaches), STI testing, pregnancy tests, or other concerns. Opening the door for them to disclose IPV over time can be part of a critical safety net for each adolescent.

Tertiary prevention involves treating a problem, once recognized, and taking steps to reduce the likelihood of this happening again. Although disclosure is not the goal, disclosures do occur, especially if the adolescent trusts the clinician. The clinician should know how to make a "warm referral," meaning connecting a patient with an advocate in person, by phone, or by virtual visit rather than merely

handing out a hotline number. This process of helping to connect to an advocate reduces barriers to seeking such help. These barriers include self-blame, (29)(30) not recognizing what is happening as abuse, (31) limited knowledge of services, (29)(30)(32) and thinking that victim services are limited just to crises. (30) Describing and routinely using such services may facilitate awareness of services, improve mental health, (33)(34)(35) and reduce the likelihood of repeated victimization. (36) Health-care centers should establish formal agreements and connections with their local violence-related services (such as a rape crisis center or domestic violence agency) and identify teen-friendly resources. Clinicians can support adolescents in making the connection to these resources when appropriate. This may include offering a patient the phone in the clinic to call a hotline (rather than using their own cell phone) or setting up a time that an advocate can come meet with that young person in the clinic. For example, "We have a lovely connection with experts who know how to help teens struggling with relationships. Would you be interested in trying to call them together?" By having these formal partnerships in place with local domestic and sexual violence prevention advocates, clinicians can be well prepared to connect a young person who discloses an abusive relationship to appropriate services. Especially if clinicians are concerned about the safety of a young person, connecting them to an advocate who can assist with safety planning is vital. For young adults, an evidence-based safety decision aid (the myPlan app, available for computers and mobile devices [[www.myplanapp.org](http://www.myplanapp.org)]) has been shown to reduce decisional conflict and increase the use of safety behaviors.

As part of the routine psychosocial assessment with adolescents (such as the HEADSS assessment [Home, Education/employment, peer group Activities, Drugs, Sexuality, and Suicide/depression]), the pediatrician can start with assessing strengths first, and include questions on safety and IPV. The astute clinician can create a safe space through which an adolescent or his or her family can access needed support. When a problem surfaces, including STIs, adolescent pregnancy, substance abuse, or other health challenges, the pediatrician can remember to keep IPV in the differential diagnosis as an underlying factor. If a young woman is experiencing reproductive coercion, providers should be prepared to discuss and offer forms of contraception that a partner cannot interfere with (such as an intrauterine device, implant, or injection). Ignoring potential relationship abuse and/or reproductive coercion may allow a harmful relationship to continue and the poor health outcomes to persist. The astute clinician can use motivational interviewing while building up the adolescent's strengths to help him or her

recognize abusive behaviors and to facilitate access to help (for self or for siblings, peers, or parents).

## CONCLUSION

Clinicians should know the resources in the area, including social work and mental health colleagues, local community and national domestic violence and rape crisis center hotlines, child protection services, and legal advocates familiar with youth law in their state. The office can showcase these resources; posters, website information ([www.thatsnotcool.com](http://www.thatsnotcool.com), [www.futureswithoutviolence.org](http://www.futureswithoutviolence.org), and [www.loveisrespect.org](http://www.loveisrespect.org)), and handouts can highlight healthy versus unhealthy relationships. Posters and resources should be multicultural, with diversity of ethnicity, sex expression, and sexual orientation represented.

Pediatricians and team leaders can invite staff from a local domestic violence agency and/or rape crisis center to attend meetings with your clinic staff and trainees. For adolescents who may find it unsafe or inaccessible to arrange times to meet with an advocate at that agency, the clinician can offer the office as a meeting site for an adolescent and an advocate from these centers.

Rather than reinventing the wheel in a practice, the pediatrician can use tools that can help provide an evidence-informed approach for conducting universal education and brief counseling. (37) The clinician can train front desk staff, receptionists, nurses, and medical assistants to be sensitive members of the team who can also recognize and provide resources to patients and families. This universal education and brief counseling approach has been tested in clinics for women and adolescents and found to increase patients' knowledge of resources and awareness of safety strategies and to reduce relationship abuse and reproductive coercion victimization. (38)(39)(40)

The clinician can share these tools with local schools, faith-based organizations, youth agencies, and athletic programs to help the adults in these programs to integrate evidence-based relationship abuse and IPV prevention into

their adolescent-focused efforts. The pediatrician should create a safe environment from the first steps into the office through which adolescents feel valued, respected, and able to proactively learn to manage their own health and well-being.

## Summary

- Based on emerging research evidence (4)(8)(11)(38) and consensus from health-care organizations, (24)(25)(26) IPV and reproductive coercion are common among adolescents and young adults, and clinic-based interventions using universal education about healthy and unhealthy relationships can have a positive effect on patients. In partnership with domestic and sexual violence prevention advocates, clinicians caring for adolescents can have a vitally important role in increasing safety and promoting healthy relationships among youth.

To view teaching slides that accompany this article, visit <http://pedsinreview.aappublications.org/content/41/2/73.supplemental>.

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1. You are invited by your local high school to speak to a group of students on the topic of intimate partner violence (IPV). You gladly accept the invitation and stress to the school principle that IPV education should target late middle school to early high school students. This is important primary prevention because among high school girls who have been in an intimate relationship, which of the following represents the prevalence of IPV in the past year?
  - A. 5%.
  - B. 10%.
  - C. 15%.
  - D. 20%.
  - E. 30%.
2. You are caring for a 20-year-old woman who has just delivered a full-term healthy baby boy. The mother, the 20-year-old father, and the baby will be living with the maternal grandmother. Other members of the household include the mother's sisters, ages 14 and 7 years. The baby's father and the mother have had an on-and-off again relationship. Occasionally during the pregnancy he would be verbally aggressive and pressure her to have sexual intercourse. One year ago, early in their relationship both parents were treated for chlamydia and gonorrhea. Their child has a substantially increased risk of which of the following conditions?
  - A. Autism spectrum disorder.
  - B. Developmental motor delays.
  - C. Gastroesophageal reflux disease.
  - D. Oppositional defiant disorder.
  - E. Physical abuse.
3. You are seeing a 15-year-old girl for a health supervision visit and conduct a confidential interview. She shares with you that she is dating a 16-year-old boy. She describes him as "nice" because he often chooses clothes for her. She also tells you that he "cares for her a lot"; he bought her a cell phone and he pays for service so he can frequently check on her. They have not had sexual intercourse. Which of the following is the most appropriate next step in management?
  - A. Insist that she stops seeing this boy.
  - B. Negotiate the inclusion of her mother to discuss this boyfriend.
  - C. Promptly initiate a contraceptive method.
  - D. Provide education about healthy and unhealthy relationships.
  - E. Refer her to a mental health counselor.
4. A 17-year-old girl comes to your office for her third injection of medroxyprogesterone acetate and retesting for chlamydia. She tested positive for chlamydia at the visit for the initiation of the contraceptive injections. Retesting for chlamydia 3 months later also was positive. Each time the girl and her boyfriend received treatment with azithromycin; however, their use of condoms has been inconsistent. This boyfriend is her first and only sexual partner. She also has poorly explained bruises on her lower arms. Which of the following is the most appropriate next step in management?
  - A. Ask questions to promote safe disclosure of IPV.
  - B. Include her boyfriend in the next office visit.
  - C. Insist that she call a crisis hotline for help now.
  - D. Make an immediate report to Child Protective Services.
  - E. Push her to disclose IPV with direct confrontational questions.

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5. Your group practice has decided to improve IPV education and intervention in the office. Informational posters and take-home cards that highlight healthy and unhealthy relationships, useful websites, and referral resources will be placed in the examination rooms. IPV training will be provided for the office staff. An in-office screening tool for IPV has been selected. Your recommendations for the patient visit are to screen and provide education and brief counseling that target which of the following groups of patients?
- A. All adolescents.
  - B. Sexual minorities.
  - C. Those with an intimate partner.
  - D. Those with a family history of domestic violence.
  - E. Those with a history of child sexual abuse.



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